FORM MH 636

CLIENT CARE/COORDINATION PLAN (To Be Used For MHS, TCM, Med. Supp., Res., Soc., and Voc. Svcs.)

Revision Date: 01/23/2006

DTI, DR and TBS will use the on-line treatment plan format in lieu of pages one / two. The third page must be completed.

DESIRED OUTCOME/LONG TERM GOALS:

Barriers to Reaching Goals:

Presenting Problems/Symptoms: (Based on DSM or client's presentation. Must be related to information from Initial Assessment or Annual Assessment.)

Do cultural/linguistic, co-occurring, and/or health factors impact on Presenting Problems?
If yes, please describe:

Functional Impairment(s) Caused by Problem(s)/Symptom(s) [Work, School, Home, Community, Living Arrangements, etc]: (Based on DSM or client's presentation. Must be related to information from Initial Assessment or Annual Assessment.)

Describe client's strengths: (As related to problems and objective in client plan)

OBJECTIVES: (Must be specific, measurable/quantifiable, attainable, realistic, time bound. Must relate to assessment, presenting problems/symptoms and functional impairment. Include cultural/linguistic, co-occurring factors, if appropriate. Include Med Support and Targeted Case Management, if appropriate)	**CLINICAL INTERVENTIONS:** (Must be related to objective. List clinical interventions for each group/individual service. Includes Med Support and Targeted Case Management, if appropriate.)	**Type/Frequency of Services to meet objectives:** (MHS - Ind and Grp); Med Sup; TCM; Soc; Residential; Voc; etc.	**OUTCOMES/Date/Initials:** To be completed at the end of the Care Plan Review timeframe, 30 days, 3, 6, 12 months or more frequently as appropriate.
Date			

Client agrees to participate by:

Staff Signature/Title:

Family Involvement
Does client consent to family involvement? Y ___ N ___ N/A ___

Does family agree to participate? Y ___ N ___

Planned Family Involvement

- ☐ Input for Initial Assessment/Annual Update
- ☐ Development of Treatment Plan
- ☐ Support for Life Domain Issues
- ☐ Psychoeducational/Support Group
- ☐ Collateral
- ☐ Family Therapy
- ☐ Crisis Management

Outcome Family Involvement

- ☐ Input for Initial Assessment/Annual Update
- ☐ Development of Treatment Plan
- ☐ Support for Life Domain Issues
- ☐ Psychoeducational/Support Group
- ☐ Collateral
- ☐ Family Therapy
- ☐ Crisis Management

Frequency of Care Plan Review	**30 Days** (Crisis Residential / other residential requirements)	**3 Months** (CalWORKs)	**6 Months** (All services except Med Sup and CM)	**12 Months** (All services)

This confidential information is provided to you in accordance with State and Federal laws and regulations, including but not limited to applicable Welfare and Institution Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law.

Name: _____ **MIS#:** _____

Agency: _____ **Prov#:** _____

Los Angeles County - Department of Mental Health

SIGNATURES * Document Reason For Lack Of Signature In Progress Note. Signature Must Be Obtained At Next Face To Face Contact.

* Client		Date	Client received a copy of the care plan. Client's Initials: Date:
Licensed Mental Health Professional		Date	
Family/Conservator/Significant Other		Date	
M.D. Medication, Medicare/Private Insurance		Date	

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Client Care Plan Continuation Page

Revision Date: 01/23/2006

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Date			
Client agrees to participate by:		**Staff Signature/Title:**	
Date			
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Date			
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COORDINATION CYCLE DATE: _____ Program/Provider Number Completing Assess/Eval _____

Date of Coordinator Face to Face Contact: _____ Translation: ☐ No ☐ Yes This plan was translated into: _____ for the client and/or responsible adult.

CYCLE PERIODS: ☐ JAN/JULY ☐ FEB/AUG ☐ MAR/SEPT ☐ APRIL/OCT ☐ MAY/NOV ☐ JUN/DEC

CalWORKs & DTI (Identify date every three months) _____ _____ _____ _____

PAYOR: ☐ Medi-Cal ☐ Medicare ☐ Private ☐ HMO ☐ None ☐ Other: (SOC, WRAP, Schiff-Card, PATH, AB3632, CalWORKs) _____

Verification of Medical/Service Necessity was completed on the Initial Assessment/Annual Assessment Update conducted on: _____ Date: Verification of Medical and/or Service Necessity is an annual requirement, please complete for current year.

COORDINATION: (Exclude Crisis and 24 hour Services - Attach printout of Episode Overview Screen) **AUTHORIZATION** (Excludes Crisis, 24 Hour, DTI, DR, TBS)

Start Date (Mo/Day/Yr)	End Date (Mo/Day/Yr)	Discharge Date	Type of Service (MHS, Meds Support, DTI, DR, TCM, Res, Voc, Soc.etc.)	Provider Name/Number	Contact Person/Team	Coordinator's Authorization Dated Initial *

* Required when services are added after Coordinator's date signature.

ADDITIONAL PLAN PARTICIPANTS/RELATIONSHIP (Reg Ctr, DPSS, Probation, DCFS, Substance Abuse, Health, other brokered non-mental health services)

_____ _____ _____ _____

Single Fixed Point of Responsibility (SFPR) Signature | Date | Licensed Mental Health Professional Signature | Date

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